

# Rationing of expensive medical care in a transition country—*nihil novum?*

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This article focuses on rationing of expensive medical care in the Czech Republic. It distinguishes between political and clinical decision levels and reviews the debate in the Western literature on explicit and implicit rules. The contemporary situation of the Czech health care system is considered from this perspective. Rationing reoccurred in the mid 90s after the shift in health care financing from fee-for-service to prospective budgets. The lack of explicit rules is obvious. Implicit forms of rationing, done by physicians at the clinical level prevail, implying uncontrolled power of the medical profession and lacking transparency for ethical considerations of equity to access. It seems to be acceptable for physicians to play the role of allocators, probably because of their experience with rationing during the socialist period. Traditional rationing stereotypes from the previous regime seem to persist despite the health care system transformation during the 90s.

Rationing" can be translated into national languages only with difficulties, despite the fact that most people understand its meaning. "Rationing", in the context of health care, mainly describes a process of distributing scarce services within a population when it is not possible to provide each patient with every health care service appropriate to his/her medical need. High-cost health care services are especially likely to be rationed. A general presumption is that the most critical time with regard to rationing is still awaiting us, as the gap between demand and resources continues to grow. Several countries, especially socialist countries and the state-run health care systems, have experienced rationing for many decades, though "rationing is indeed international and not just a by-product of the way Britain's National Health Service is designed or funded".<sup>1</sup>

The problem of rationing in the Czech Republic has been studied with respect to different concepts of rationing. Foreign literature makes a distinction between political and economic decisions, and clinical decision making.<sup>2</sup> Due to variability of resources and cultural norms, the kind of rationing that is done by the physician is principally determined by societal context. It is the physician, however, not the politician or health manager who holds personal responsibility for quality of care.

## RATIONING REQUIRES A MIX OF EXPLICIT AND IMPLICIT RULES

Explicit rationing relies on clearly defined indicators such as age, marital status, clinical condition, sex, and financial cover. Apart from the negative social impact, the tendency towards a strict standardisation in health care provision, and low sensitivity to individual patient differences and patient choice may be other disadvantages. Mechanic says that "explicit guidelines, however, are likely to fall short relative to the complexity of circumstances surrounding serious illness or to be so detailed that they are impracticable".<sup>3</sup> Explicit rules promise distinctive transparency and accountability in medical decision making; nevertheless, there is no doubt that strictly applied, they may even be counterproductive.

Implicit rationing is based on non-obvious intraprofessional norms and rules that are developed by clinicians themselves.

The professional assessment of health needs often includes judgments about intelligence, family circumstances, social status, profession and/or personality traits.<sup>4</sup> Physicians are supposed to be the best-qualified persons to make decisions about the provision of health care services. The fundamental value that is at the root of implicit rationing is the ethical responsibility of the physician for the patients' wellbeing. Implicit rationing has been criticised because of secretiveness and loss of public control over medical decisions and because of the fact that it simply leads to a false social illusion about universal right to health. Assertive patients (better educated, rich, powerful, and motivated) may be preferred. Physicians are taught that no discrimination on grounds of employment status, family circumstances, lifestyle, learning disability, age, race, sex, social position, financial status, religion, or place of abode is allowed<sup>5</sup>; however, they have to cope in one way or another with everyday limits.

The appropriate forms of rationing in democratic societies are hotly discussed. According to Klein and Hunter, quoted by Rao: "rationing is inescapably a political process", yet everyday medical practice requires "muddling through elegantly". This pragmatic approach was criticised by Jammi Rao<sup>6</sup> who believes that delegation of enforcement power from politicians to physicians is not legitimate. He concludes, that "ad hoc decision making by unelected managers and doctors is far from elegant . . . and . . . has led to widespread inequalities in access, a general decline in quality, and arbitrary and inefficient allocation of resources". In practice, both forms of rationing are mixed in every health care system. Despite the fact that explicit rationing has recently been advocated as more appropriate (equitable and efficient), it is clear that medical decision making cannot be fully determined by external rules. According to Mechanic<sup>7</sup>: "implicit rationing at the point of service is more sensitive to the complexity of medical decisions and the needs and personal and cultural preferences of patients" and further, "more conducive to stable social relations and a lower level of conflict". Mechanic's main thesis<sup>8</sup> is that "rationing at the microlevel must be left for doctors and patients to work out among themselves".

On the contrary, Ellis<sup>10</sup> believes that "fidelity (caring for patients) and stewardship (rationing resources) are ethically incompatible when attempted by the same individual". He

further concludes that “making the clinician responsible for rationing puts too much power in one person’s hand”.<sup>10</sup> If implicit rationing is based on fundamental trust between the physician and patient, then this double responsibility of the physician may lead to a strong professional role conflict and can make the patients unsure.

## THE PRACTICE OF RATIONING IN THE 1990s IN THE CZECH REPUBLIC

The health care system in the Czech Republic was not a matter of public dispute during the socialist period when the congruency of interests of state, public, and professional groups was enforced by political means. Due to underfunding and “the iron curtain” new medical technologies were hardly ever available, and then only usually for the politically privileged or on the basis of informal contacts. The total health care expenditure in the Czech Republic varied between 4.5% and 5% of the gross domestic product (GDP) at the end of the 80s. That is why the transformation of the Czech health care system after 1989 has had the reduction of this technological gap as a priority.

Between 1991 and 1993 the state-run system was discarded in favour of a mandatory health insurance programme of the Bismarckian tradition. Financing of health care was separated from the state budget and was delegated to public insurance companies who have a corporate status; there are eight currently. No private insurance companies are allowed to provide basic health care insurance. The main source of insurance cover is the General Health Insurance Company (GHIC), which covers at least 75% of the Czech population, the rest being insured by seven departmental, occupational, corporate, and other health insurance companies, which are also publicly funded and have universal access. The constitutional right to health protection and health care on the basis of equity is declared in the Charter of Basic Rights and Freedoms (1992) which continues and prolongs the tradition from the socialist era.

The main focus has been on political, organisational, and economic issues, while the ethical dimension of the transformation has been neglected. No attention was paid to rationing because of the optimistic view that rationing would be eliminated by open market and fee-for-service payment mechanisms. Obviously, if measured by the increased number of technological devices, the Czech health care system has made enormous progress over the last decade. Such a dramatic increase in technological equipment was fostered by the retrospective reimbursement scheme that was universal in the initial transformation period. This enthusiasm did not last long. During the next three to four years a persisting deficit between public resources and health care expenses occurred. The historical turning-point came in 1997, when fixed budgets in the hospitals and capitation payment to general practitioners replaced the fee-for-service scheme. The shift to prospective payments with upper limits led to freezing the escalation of volume of care and, in some cases, even to a decrease of previously provided services. According to data released by The General Health Insurance Company in 1998, the volume of hospital services fell on average to 80% of the year before while the minimum required by the GHIC was 75% of that provided in the previous year. Physicians warned the public that under such constraints the quality and accessibility of care would no longer be sustainable. The rapid decrease in the volume of care may also have been a special form of protest by the medical profession against public regulations. Rationing has once again become a topic for discussion.

Restoration of an old stereotype—that is, budgeting, under changed social conditions (democratic society, free choice of health care provider, new social stratification, increasing income differentiation and a high degree of vertical mobility) may bring some ethical risks and problems that remain

## Interview topics

Is rationing necessary in the new health care system?  
Are some social groups disadvantaged with regard to access to modern technologies?  
Who performs rationing?  
Which rules prevail (explicit or implicit)?

neglected. This article aims to inquire about the current status and practice of rationing of expensive medical technologies in the Czech Republic. We used three techniques in our inquiry: the principle approach was in-depth interviews, followed by observation, and document analysis. We carried out a series of 13 interviews with the heads of tertiary care departments, mostly in the teaching hospitals. (Selected technologies: cardiologic stents, lung stents, abdominal stents, dialysis, implantable defibrillators, cochlear implants, hip replacement, Leksell gamma knife, imaging technologies, oncological treatment-chemotherapy. Organ transplantation was not included because of the fact of other type of restrictions regarding human organs.) In the text which follows we describe the different different ways of rationing as brought about by the transformation process and then we summarise the views of the physicians we interviewed.

## NEW FORMS OF RATIONING IN THE 1990s

### Insurance fund affiliation as a precondition of access to health care

Health insurance funds were introduced in the early 90s with the idea of mutual competition. Therefore one of the suggested ways of explicit rationing was that restricted types of care could be provided on the basis of the patient fund affiliation. Several health insurance funds tried to achieve privileges for their clients as a part of their contracts with providers. Apart from the surplus services, time on a waiting list and in the consultation room was debated in the mid 90s. Later discussions made it clear that in the framework of statutory public health insurance such distinction among patients was not acceptable. Despite this fact, whenever contractual problems between the providers and insurance funds occur the patient fund affiliation is mentioned once again as a contingent restricting factor.

### Stipulated areas—overlapping of two modes of health care

An uncertain situation can be observed in the geographic accessibility of care. In the first period of transformation, free choice of provider was declared to be a basic patient right in the *Public Health Insurance Act* of 1991. Hospitals and individual practitioners were motivated by fee-for-service; it led to competition for clients and maximal increase in the production of care. The so-called “stipulated catchment areas” that divided the geographic coverage during the socialist era were abolished. The public hospitals are still supposed to care for respective geographic areas as before, nevertheless since the transformation they are allowed to care for patients from outside their catchment area if they wish.

Unfortunately, though both principal laws on health care explicitly mention “the stipulated catchment areas”, no formal document defining them is publicly available. It is almost certain that physicians and managers refer to former geographical areas from the socialist regime that persist in oral tradition. If a hospital refuses to admit a patient, there is no chance of revising the decision. No law deals with the issue of who is responsible for the “catchment areas”, who defines them, and who publicises them. The Health Ministry supposes that the hospital founding documents (statutes) will explicitly declare their geographical coverage in the future, but as yet this has not happened. This is crucial from the point of view of

### An example of a “gentlemen’s agreement”

The annual number of implantable defibrillators is limited by the health insurance companies to 10 per year. There are eight cardiosurgery centres in the Czech Republic who share this number. Therefore an informal expert approval procedure of each case has been introduced in order to enhance transparency of decision making among the clinicians themselves. The procedure consists in computer exchange of relevant clinical information on the patient’s status, prognosis, and justification of the medical solution among the heads of the centres. Approval of a majority of the informal commission is necessary.

subsidiarity and continuity of care. It is also an ethical problem because patients can be denied care even when they are fully entitled to it by law. According to the *Public Health Insurance Act No 48/1997*: “the physician shall not be permitted to refuse the insured person from a stipulated catchment area and in the event that urgent care is required”; however, both of these aspects are exclusively controlled by physicians. In our opinion it is a hazardous combination when the health care provider who is obliged by law to care for an area determines that area and in addition is the only competent person to admit patients. This practice may well permit capricious patient selection or pure chance to operate, where both denial and privileged admissions from other areas are concerned.

### Sponsoring and charity

Hospitals, hospital departments, and individual physicians have tried to compensate for their losses through “charity foundations”. Patients, citizens, or corporate donors can contribute to these charities that are founded and administered by hospital doctors on the basis of non-profit civic associations, separately from the hospital management. It is likely that this sponsoring may privilege some patients in their access to the most restricted services—especially hip replacement, cardiosurgery, and eye treatment. In one case a physician admitted that the fact of sponsoring may be taken into account in the course of clinical decision making. We assume that both waiting time and the quality of material may be influenced. Nevertheless, in his opinion, “the doctors always try to balance the health needs of different patients and not harm patients in acute need” (senior consultant in orthopaedics, personal communication, 2000). According to the official statement of the Czech Medical Chamber,<sup>11</sup> sponsoring must not have any influence on the provision of health care services and must not be negotiated at the moment of acute health need. (Sponsoring is voluntary and provides the only legal way that patients can make financial contributions to care that is provided under public coverage. Patients’ co-payments are allowed when the services are excluded from the health care package.)

### Public regulation of the most expensive technologies—between explicit and implicit rules

The GHIC has recently organised a special commission to regulate several therapies which involve the most expensive technologies and drugs—for example, cochlear and pace-maker implants, neuromodulation treatment in epileptic patients, interferon beta treatment in multiple sclerosis, and in vitro fertilisation. These therapies are financed directly by insurance funds, apart from the common hospital budget. The commission reviews the professional indications for treatment and upon its acceptance it issues final approval of the health care provision. The commissioners come from health insurance companies, clinical facilities, the Health Ministry, and the public. The major deciding factor for treatment is the medical

assessment of the patient’s health condition. The psychological and social situation of the patient, and his/her motivation (or the motivation of the family) is often taken into account—for example, in cochlear implants, the educational prospects of the child-patient and the likelihood of his/her family to cooperating during subsequent therapeutic and rehabilitation periods are examined. Only those patients who have already been selected at previous stages by medical professionals are submitted for the more or less formal approval by the commission.

### RATIONING AS VIEWED BY THE PHYSICIANS WE INTERVIEWED

In this part we summarise the opinions of the physicians we interviewed. We are aware that the views of the physicians represent subjective reflection. This can be interpreted only within the framework of medical professional norms, the core value being clinical autonomy. We are also aware that any generalisation of our conclusions might be hazardous until they are verified in further research.

The first transformation period led to escalation of services and an increase in technological equipment. Due to the remarkable improvement in quality and accessibility of expensive care physicians tend to declare their satisfaction despite some critical voices, having in mind the previous shortages. Thanks to fee-for-service, a historical maximum volume of care was achieved in the mid 90s and the clinical supply/demand stabilised. Most physicians evaluated this as sufficient when related to the macroeconomic reality of the Czech Republic and when compared to the previous period; the only unmet need being admitted is hip replacement. In the opinion of the tertiary care physicians all patients referred to them receive care appropriate to their clinical condition. Contrary to mass media reports of dramatic threats to standards of health care the clinicians reported no substantial decrease in quality of care in recent times. In spite of the documented reduction in volume of care after 1997 physicians at the tertiary level did not confirm any urgent unmet need. This leads us to an assumption that rationing happens at rather lower levels of the health care system. This is due to insufficient information about the availability and eligibility of tertiary care among primary care physicians and to a complicated referral system. However, the professional attitude of physicians, which dictates that they do not to discuss clinical issues in public cannot be ignored. Also, a tendency towards depicting the situation as better than it is, in order to preserve their internal control over the field from those outside the profession, cannot be excluded.

Patient selection is the crucial dilemma of rationing. Physicians tend to emphasise that clinical criteria are the only relevant ones—for example, in cochlear implants, profound deafness, according to the definition of the World Health Organisation, is the necessary condition of a treatment allocation. In many cases they make judgments concerning family situation, learning abilities, sponsoring, professional career, and age but their decisions are justified only with medical arguments. Social and demographic characteristics may play a certain role, especially when long term compliance is necessary for a successful treatment outcome; nevertheless, in their opinion, no patient is discriminated against on grounds of social or ethnic origin or age. No flat age limits are used; however, some services are provided under different conditions when patients are older. For example, the more expensive hip replacement operation is conducted on younger patients who are expected to live longer and be more physically active, while the older patients receive a cheaper type of hip replacement.

It is the physician who determines the availability of care. Informal collegial contacts between physicians at tertiary, secondary, and primary levels were mentioned as factors that



affect the speed at which patients enter and proceed through the health care system. On the other hand, the same effect can be achieved by assertive patients or their families, because of the fact that most tertiary facilities have no clear geographical responsibility and can admit patients from the entire Czech Republic. Physicians are aware of an absence of rules and they try to compensate for the gap by their own efforts, developing “a gentlemen’s agreement” on approval procedure or on territory division among the specialised facilities (see box 2).

Waiting lists, either in the form of book or electronic lists, are exclusively in the hands of physicians and are not accessible to hospital administrators nor supervised by insurance managers. Only clinical arguments make changes in the waiting lists officially acceptable. Even in those technologies where formal commission approval (see above) is necessary, the medical opinion is the crucial one; however, in dubious cases the sick are entitled to appeal against a denial.

## CONCLUSIONS

Rationing leads to a conflict of interests that can be reduced by specific agreements between politicians and physicians. Although politicians make their health policy solutions while having in mind the population as a whole, they are not keen to inform the public about urgent limitation of care for financial reasons, because of the fear of public protests. In every constitutional “right to health care”, there is tension between political declarations and their pragmatic implementation. The current state of debate shows that rationing has once more become an everyday practice for many physicians in the Czech Republic; but due to the enormously increased level of medical care during the first transformation years it is less frustrating even now when economic pressures have recurred. No clear political responsibility has been declared, therefore rationing, a reality since 1997, relies predominantly on implicit rules. The physicians have been delegated full authority to make decisions on accessibility and availability of care. Neither health insurance companies nor hospital management can influence rationing at the clinical level and may only establish an external economic framework for clinical work. The medical indicators and conditions on which allocation decisions are based are under the exclusive control of the medical profession. The clinical need and prognosis of the patient has become the “alpha and omega” of argumentation. That is to say that the physicians retain their superiority in the rationing debate by emphasising the overwhelming importance of their clinical judgment. Moreover by using clinical language they exclude lay persons from the discussion.

The physicians in leading positions seem to be aware of their stewardship responsibility for making the best possible use of restricted financial resources with regard to cost-effectiveness. Czech medical professionals perceive it as their professional task and privilege as experts to carry out rationing. This is principally right due to their qualifications and sense of personal responsibility but this task requires a high degree of moral self control and an ethical awareness of the rationing dilemma. Many aspects are regulated informally by non-fixed gentlemen’s agreements on labour division or on referrals. From the societal view the situation becomes unclear for public bodies and the lay public as well. Uncontrolled power and decision making delegated to medical professionals may be their reward for the absence of rationing done at the political level. The medical view of rationing is much more optimistic than it is officially presented in the mass media. Either the physicians tend towards idealisation with the aim of preserving the status quo—that is, their uncontrolled power, or the mass media are dramatising the situation because of their own interests and values.

When compared to the Western debate, Czech physicians are more realistic and pragmatic in putting up with their allocator role. The question may arise, why are the Czech

## Summary of beliefs about rationing recorded in the interviews

- Rationing is not a hot issue for clinicians at the tertiary level (probably because of patient selection at the primary and secondary levels and comparison of the current situation with the previous period).
- Contemporary Czech medicine exceeds the economic situation of the country (when related to the total Czech GDP and its share of health care).
- The role of allocator and economic responsibility are integral parts of medicine (the physicians did not separate economic issues from the medical ones).
- Clinical criteria are the only acceptable explicit rules and intraprofessional regulation is the best way of rationing

physicians not as frustrated as some Western physicians by the fact that not every kind of care available may be affordable and accessible? At the moment, we assume they are not so frustrated as their Western counterparts because of the influence of their previous professional experience during the socialist period, when rationing due to underfunding was an everyday task. According to Lilly Hoffman, uncontrolled clinical autonomy may compensate for the lost corporate autonomy during the socialist era.<sup>12</sup>

The conclusion is that much is left to hidden processes, improvisation and chance. The debate on rationing is negatively influenced by a generally low level of willingness to make ethical judgments openly and publicly and by the historically conditioned fear of collective solutions, which are seen as a threat to human freedom. Both of these realities paralyse the articulation of rationing as a public issue. Traditional value systems, as offered by religion, are not sufficient for moral assessment, because of the prevailing “atheistic” nature of Czech society. This is enhanced by low engagement of the public in health matters and by their view of the medical profession as paternalistic.

Yet, it would be unacceptable from the view of justice to simply transfer the rationing stereotypes from the socialist regime and apply them in new democratic conditions. Looking for equity and justice, we have to introduce more transparency in the Czech health care system, including some explicit rules of rationing and the establishment of an autonomous body which could independently review difficult cases. A public as well as a medical discussion on equity in the Czech health care system is necessary, though we fully respect the fact that the space for explicit rules is limited and that many circumstances of treatment will still be negotiated in the intimate relationship between the physician and the patient. In the transition countries in Central and Eastern Europe, however, including the Czech Republic, the risk of the black market ruling the distribution mechanisms should not be neglected.

Finally, feelings of justice in a democratic society are principally connected with equal chances, transparency, accountability, and public control. As Robert Spaemann<sup>13</sup> says: “... it is contrary to the fundamental requirement of symmetry in relationships made by justice that some people should be entirely at the mercy of others and that they should depend on these people acting justly. That is why control of power and the distribution of sources of power are part and parcel of our idea of a situation where justice prevails. It is also why a person, or a group of persons, in a position of power can only be regarded as just if they are ready to accept that their powers should be limited by legal institutions”.

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